2001 IHCIF

Final Results for the FY 2001 Indian Health Care Improvement Fund

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April, 2001

Tab A

Table of the funds distribution among local operating units

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April, 2001

FY 2000 FDI: Table 8 -- IHCIF Distribution

FY 2001 Distribution of the $40 Million IHCIF

Area	Local Operating Unit	Users	FEHBP %	To get to 60%	IHCIF Allocation	IHCIF / User	Revised %
Aberdeen	Sac & Fox	813	54%	$170,321	$16,000	$20	54%
Aberdeen	Winnebago	4,189	55%	$626,318	$58,000	$14	55%
Aberdeen	Omaha	3,773	61%	$0	$0	$0	61%
Aberdeen	Santee	1,372	37%	$981,778	$91,000	$66	39%
Aberdeen	Northern Ponca	1,667	44%	$864,622	$80,000	$48	46%
Aberdeen	Turtle Mountain	13,760	67%	$0	$0	$0	67%
Aberdeen	Standing Rock	9,864	46%	$3,765,248	$348,000	$35	47%
Aberdeen	Spirit Lake (Ft. Totten)	5,201	44%	$2,341,131	$216,000	$42	46%
Aberdeen	Three Affiliated (Ft. Berthold)	5,944	44%	$2,568,959	$237,000	$40	46%
Aberdeen	Trenton	1,563	45%	$723,387	$67,000	$43	47%
Aberdeen	Rapid City	12,324	42%	$5,587,286	$516,000	$42	44%
Aberdeen	Cheyenne River	8,427	44%	$3,762,496	$347,000	$41	45%
Aberdeen	Pine Ridge	23,613	59%	$864,321	$80,000	$3	59%
Aberdeen	Rosebud	13,731	53%	$2,553,571	$236,000	$17	54%
Aberdeen	Sisseton-Wahpeton	6,088	44%	$2,774,736	$256,000	$42	45%
Aberdeen	Yankton	4,278	59%	$159,781	$15,000	$4	59%
Aberdeen	Flandreau	1,767	38%	$1,179,929	$109,000	$62	40%
Aberdeen	Crow Creek	3,853	53%	$832,563	$77,000	$20	53%
Aberdeen	Lower Brule	2,113	53%	$465,001	$43,000	$20	53%
Aberdeen Total		**124,338**	**52%**	**$30,221,451**	**$2,792,000**	**$22**	**53%**
Alaska	Aleutian Pribilof Islands Associatic	1,019	83%	$0	$0	$0	83%
Alaska	Arctic Slope Regional Tribe	5,028	57%	$598,371	$55,000	$11	57%
Alaska	Bristol Bay Area Health	7,152	67%	$0	$0	$0	67%
Alaska	Chugachmiut Tribe	1,849	68%	$0	$0	$0	68%
Alaska	Copper River Native Associaton	497	96%	$0	$0	$0	96%
Alaska	Eastern Aleutian Tribe	968	51%	$406,678	$38,000	$39	52%
Alaska	Kenaitze Indian Tribe	1,309	56%	$175,860	$16,000	$12	57%
Alaska	Ketchikan Indian Corporation	3,184	37%	$3,104,875	$287,000	$90	39%
Alaska	Kodiak	2,777	48%	$1,435,899	$133,000	$48	49%
Alaska	Maniilaq	7,200	97%	$0	$0	$0	97%
Alaska	Metlakatla Indian Tribe	1,490	37%	$1,555,804	$144,000	$97	39%
Alaska	Misc. Anchorage Tribes	341	151%	$0	$0	$0	151%
Alaska	Ninilchik	224	76%	$0	$0	$0	76%
Alaska	Norton Sound	7,411	63%	$0	$0	$0	63%
Alaska	Seldovia	744	33%	$889,227	$82,000	$110	35%

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Alaska	Southcentral Foundation	28,644	74%	$0	$0	$0	74%
Alaska	Southeast Alaska Regional Health	11,334	67%	$0	$0	$0	67%
Alaska	Tanana Chiefs Conference	13,032	45%	$7,160,588	$661,000	$51	47%
Alaska	Yukon Kuskokwim	19,790	49.5%	$7,452,562	$688,000	$35	50%
Alaska Total		**113,993**	**62%**	**$22,779,864**	**$2,104,000**	**$18**	**63%**
Albuquerque	Albuquerque	31,003	40%	$13,474,721	$1,244,000	$40	42%
Albuquerque	Acoma-Canoncito-Laguna	11,689	50%	$2,713,176	$250,000	$21	51%
Albuquerque	Mescalero	4,247	53%	$736,921	$68,000	$16	54%
Albuquerque	Santa Fe	18,362	54%	$2,358,936	$218,000	$12	55%
Albuquerque	Zuni	9,125	53%	$1,711,738	$158,000	$17	53%
Albuquerque	Ramah	2,100	46%	$904,132	$83,000	$40	47%
Albuquerque	So Colorado Ute	5,256	55%	$738,467	$68,000	$13	55%
Albuquerque	Ysleta Del Sur	861	86%	$0	$0	$0	86%
Albuquerque	Jicarilla	3,739	41%	$1,891,964	$175,000	$47	43%
Albuquerque Total		**86,382**	**48%**	**$24,530,055**	**$2,264,000**	**$26**	**49%**
Bemidji	Bad River	1,928	39%	$1,091,366	$101,000	$52	41%
Bemidji	Bay Mills	1,172	34%	$909,891	$84,000	$72	36%
Bemidji	Fond Du Lac	5,475	34%	$3,695,047	$341,000	$62	36%
Bemidji	Forest County	830	37%	$568,214	$52,000	$63	39%
Bemidji	Grand Portage	472	40%	$261,450	$24,000	$51	42%
Bemidji	Grand Traverse	1,506	50%	$382,902	$35,000	$23	51%
Bemidji	Greater Leech Lake	9,217	37%	$5,163,606	$477,000	$52	39%
Bemidji	Greater Red Lake	7,232	60%	$71,475	$10,000	$1	60%
Bemidji	Greater White Earth	7,743	48%	$2,240,828	$207,000	$27	49%
Bemidji	Ho-Chunk	3,530	39%	$1,998,997	$185,000	$52	41%
Bemidji	Huron Potawatomi	646	34%	$466,863	$43,000	$67	37%
Bemidji	Keweenaw Bay	1,673	36%	$1,149,952	$106,000	$63	38%
Bemidji	Lac Courte Oreilles	3,682	34%	$2,445,979	$226,000	$61	37%
Bemidji	Lac Du Flambeau	2,655	41%	$1,364,749	$126,000	$47	43%
Bemidji	Lac Vieux Desert	395	76%	$0	$0	$0	76%
Bemidji	Little River Ottawa	1,003	36%	$677,353	$63,000	$63	38%
Bemidji	Little Traverse Odawa	2,640	37%	$1,482,076	$137,000	$52	39%
Bemidji	Lower Sioux	523	32%	$420,505	$39,000	$75	35%
Bemidji	Gun Lake	291	35%	$213,388	$20,000	$69	37%
Bemidji	Menominee	7,148	29%	$5,486,246	$506,000	$71	32%

FY 2000 FDI: Table 8 -- IHCIF Distribution

FY 2001 Distribution of the $40 Million IHCIF

Area	Local Operating Unit	Users	FEHBP %	To get to 60%	IHCIF Allocation	IHCIF / User	Revised %
Bemidji	Hannahville	797	35%	$577,817	$53,000	$66	38%
Bemidji	Mille Lacs	2,125	31%	$1,765,904	$163,000	$77	34%
Bemidji	Bois Forte/Nett Lake	1,177	52%	$238,211	$22,000	$19	53%
Bemidji	Oneida	7,519	33%	$4,945,762	$456,000	$61	35%
Bemidji	Pokagon Potawatomi	2,525	31%	$2,176,526	$201,000	$80	34%
Bemidji	Prairie Island	344	45%	$152,335	$14,000	$41	47%
Bemidji	Shakopee	452	33%	$380,161	$35,000	$77	36%
Bemidji	Red Cliff	1,560	38%	$1,007,557	$93,000	$60	40%
Bemidji	Saginaw Chippewa	2,150	29%	$1,910,978	$176,000	$82	32%
Bemidji	Saulte Sainte Marie	9,210	34%	$5,619,942	$519,000	$56	37%
Bemidji	Sokaogon	549	37%	$337,703	$31,000	$56	40%
Bemidji	St Croix	1,537	27%	$1,516,583	$140,000	$91	30%
Bemidji	Stockbridge-Munsee	1,365	55%	$194,754	$18,000	$13	56%
Bemidji	Upper Sioux	362	41%	$198,011	$18,000	$50	43%
Bemidji Total		**91,434**	**39%**	**$51,113,131**	**$4,721,000**	**$52**	**41%**
Billings	Blackfeet	12,391	62%	$0	$0	$0	62%
Billings	Crow	12,781	72%	$0	$0	$0	72%
Billings	Ft Belknap	5,733	74%	$0	$0	$0	74%
Billings	Ft Peck	9,668	61%	$0	$0	$0	61%
Billings	No. Cheyenne	7,599	68%	$0	$0	$0	68%
Billings	Wind River	10,677	50%	$2,444,354	$226,000	$21	51%
Billings	Flathead	10,699	47%	$3,680,793	$340,000	$32	48%
Billings	Rocky Boy	5,143	52%	$1,133,634	$105,000	$20	52%
Billings Total		**74,690**	**60%**	**$7,258,781**	**$671,000**	**$9**	**61%**
California	Berry Creek/Mooretown/Feather R	3,054	37%	$1,820,480	$168,000	$55	39%
California	Cabezon	11	244%	$0	$0	$0	244%
California	Central Valley	5,087	35%	$3,158,385	$292,000	$57	37%
California	Chapa De	3,602	38%	$2,076,174	$192,000	$53	40%
California	Colusa	236	20%	$299,762	$74,000	$314	30%
California	Consolidated	2,402	35%	$1,576,494	$146,000	$61	38%
California	Greenville	1,218	31%	$977,050	$90,000	$74	34%
California	Hoopa	2,803	55%	$374,715	$35,000	$12	55%
California	Indian Health Council	4,400	52%	$883,429	$82,000	$19	53%
California	Karuk	1,758	52%	$393,155	$36,000	$20	52%
California	Lake County	1,251	37%	$838,452	$77,000	$62	39%

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California	Lassen	899	46%	$373,233	$34,000	$38	47%
California	Modoc	184	105%	$0	$0	$0	105%
California	Northern Valley	1,552	38%	$934,517	$86,000	$55	40%
California	Pit River	917	60%	$3,170	$0	$0	60%
California	Quartz Valley	106	49%	$31,166	$10,000	$94	53%
California	Redding Rancheria	3,812	53%	$633,545	$58,000	$15	54%
California	Riverside/San Bernardino	9,398	63%	$0	$0	$0	63%
California	Round Valley	1,194	41%	$648,749	$60,000	$50	43%
California	Santa Ynez	522	44%	$251,916	$23,000	$44	46%
California	Shingle Springs	671	45%	$296,376	$27,000	$40	47%
California	Sonoma County	3,923	40%	$2,065,631	$191,000	$49	42%
California	Southern Indian Health Council	1,833	88%	$0	$0	$0	88%
California	Sycuan	96	86%	$0	$0	$0	86%
California	Table Mountain	26	94%	$0	$0	$0	94%
California	Toiyabe	2,672	58%	$164,303	$15,000	$6	58%
California	Tule River	2,414	57%	$162,753	$15,000	$6	58%
California	Tuolumne	1,648	52%	$348,123	$32,000	$19	53%
California	United Indian Health Services	6,186	41%	$2,903,000	$268,000	$43	43%
California	Warner Mountain	114	109%	$0	$0	$0	109%
California Total		**63,989**	**49%**	**$21,214,578**	**$2,011,000**	**$31**	**50%**
Nashville	Alabama Coushatta	864	61%	$0	$0	$0	61%
Nashville	Catawba	1,185	71%	$0	$0	$0	71%
Nashville	Cherokee	11,615	56%	$981,005	$91,000	$8	56%
Nashville	Chitimacha	422	66%	$0	$0	$0	66%
Nashville	Choctaw	8,210	61%	$0	$0	$0	61%
Nashville	Coushatta	427	80%	$0	$0	$0	80%
Nashville	Houlton Band Of Maliseet	389	100%	$0	$0	$0	100%
Nashville	Jena Band Of Choctaw	128	83%	$0	$0	$0	83%
Nashville	Miccosukee	709	66%	$0	$0	$0	66%
Nashville	Micmac	535	113%	$0	$0	$0	113%
Nashville	Mohegan	1,024	38%	$752,674	$69,000	$67	40%
Nashville	Narragansett	723	80%	$0	$0	$0	80%
Nashville	Oneida	2,079	48%	$708,122	$65,000	$31	49%
Nashville	Pass.. Township	923	75%	$0	$0	$0	75%
Nashville	Pass.-Pleasant Point	1,190	74%	$0	$0	$0	74%

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Nashville	Penobscot	1,406	73%	$0	$0	$0	73%
Nashville	Pequot	982	37%	$769,058	$71,000	$72	39%
Nashville	Poarch Creek	2,371	51%	$477,426	$44,000	$19	52%
Nashville	St. Regis Mohawk	5,061	39%	$2,591,157	$239,000	$47	40%
Nashville	Seminole	3,347	53%	$555,365	$51,000	$15	54%
Nashville	Seneca	4,973	56%	$540,410	$50,000	$10	56%
Nashville	Tunica-Biloxi	251	72%	$0	$0	$0	72%
Nashville	Wampanoag Of Gayhead	303	55%	$46,708	$10,000	$33	56%
Nashville Total		**49,114**	**57%**	**$7,421,924**	**$690,000**	**$14**	**58%**
Navajo	Chinle	28,625	40%	$12,157,880	$1,122,000	$39	42%
Navajo	Tsaile	9,359	33%	$6,179,970	$570,000	$61	35%
Navajo	Crownpoint	22,337	39%	$9,998,850	$923,000	$41	41%
Navajo	Fort Defiance	31,072	45%	$10,540,494	$973,000	$31	46%
Navajo	Gallup	35,166	59%	$437,254	$40,000	$1	59%
Navajo	Tohatchi	9,362	56%	$818,750	$76,000	$8	57%
Navajo	Kayenta	15,526	35%	$8,448,029	$780,000	$50	37%
Navajo	Inscription House	4,975	31%	$3,737,466	$345,000	$69	33%
Navajo	Shiprock	46,322	56%	$3,488,013	$322,000	$7	57%
Navajo	Dzilth Na O Dith Hle	5,993	43%	$2,478,482	$229,000	$38	44%
Navajo	Tuba City	29,087	48%	$7,173,212	$662,000	$23	49%
Navajo	Winslow	15,998	39%	$7,443,601	$687,000	$43	41%
Navajo Total		**253,821**	**47%**	**$72,902,001**	**$6,729,000**	**$27**	**48%**
Oklahoma	Claremore	32,085	45%	$9,506,030	$877,000	$27	46%
Oklahoma	Clinton	11,682	43%	$4,120,995	$380,000	$33	45%
Oklahoma	Haskell	4,006	39%	$2,036,067	$188,000	$47	41%
Oklahoma	Holton	1,819	46%	$713,843	$66,000	$36	47%
Oklahoma	Lawton	23,933	46%	$6,358,242	$587,000	$25	48%
Oklahoma	Pawnee	10,636	50%	$2,236,752	$206,000	$19	51%
Oklahoma	Tahlequah	16,935	63%	$0	$0	$0	63%
Oklahoma	Wewoka	11,241	33%	$6,683,134	$617,000	$55	35%
Oklahoma	Abs Shawnee	5,242	34%	$3,429,791	$317,000	$60	36%
Oklahoma	Chickasaw	30,421	49%	$6,522,464	$602,000	$20	50%
Oklahoma	Cherokee	68,283	31%	$39,496,843	$3,645,000	$53	33%
Oklahoma	Choctaw	32,975	50%	$6,457,083	$596,000	$18	51%
Oklahoma	Creek	24,829	31%	$14,128,754	$1,304,000	$53	34%

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Oklahoma	Kaw	1,170	37%	$724,137	$67,000	$57	39%
Oklahoma	Kickapoo Of Kansas	599	51%	$140,287	$13,000	$22	52%
Oklahoma	Kickapoo Of Texas	538	71%	$0	$0	$0	71%
Oklahoma	Ponca Tribe Of Oklahoma	4,260	38%	$2,315,906	$214,000	$50	40%
Oklahoma	Kickapoo Of Oklahoma	5,939	29%	$4,411,846	$407,000	$69	32%
Oklahoma	Citizen Potawatomi	12,020	29%	$7,899,478	$729,000	$61	32%
Oklahoma	Iowa Of Oklahoma	1,248	22%	$1,272,917	$259,000	$208	30%
Oklahoma	Sac And Fox Of Oklahoma	8,651	26%	$6,597,087	$776,000	$90	30%
Oklahoma	Wyandotte / E Shawnee	952	43%	$435,373	$40,000	$42	44%
Oklahoma	Miami Consortium	8,398	32%	$5,279,123	$487,000	$58	35%
Oklahoma Total		**317,864**	**40%**	**$130,766,153**	**$12,377,000**	**$39**	**42%**
Phoenix	PIMC	49,783	49%	$12,384,449	$1,143,000	$23	50%
Phoenix	Keams Canyon/Hopi	6,882	66%	$0	$0	$0	66%
Phoenix	U&O	4,088	52%	$824,439	$76,000	$19	53%
Phoenix	Whiteriver	15,016	47%	$4,650,077	$429,000	$29	48%
Phoenix	Ft. Yuma	3,787	60%	$34,174	$10,000	$3	60%
Phoenix	Colorado River	5,247	60%	$0	$0	$0	60%
Phoenix	Peach Springs/Supai	2,449	56%	$302,329	$28,000	$11	56%
Phoenix	San Carlos	11,830	37%	$6,523,921	$602,000	$51	39%
Phoenix	Elko	2,193	63%	$0	$0	$0	63%
Phoenix	Duckwater	183	150%	$0	$0	$0	150%
Phoenix	Ely	370	76%	$0	$0	$0	76%
Phoenix	Gila River	19,771	44%	$7,238,771	$668,000	$34	45%
Phoenix	PITU	426	138%	$0	$0	$0	138%
Phoenix	Owyhee	1,553	127%	$0	$0	$0	127%
Phoenix	Schurz/Walker River	1,043	72%	$0	$0	$0	72%
Phoenix	Fallon/Lovelock/Yomba	1,816	52%	$421,779	$39,000	$21	53%
Phoenix	Pyramid Lake	1,723	42%	$902,577	$83,000	$48	44%
Phoenix	Reno-Sparks/Nevada Urban	3,359	44%	$1,462,960	$135,000	$40	46%
Phoenix	Las Vegas/Moapa	1,152	46%	$485,074	$45,000	$39	48%
Phoenix	Ft. Mcdermitt	848	52%	$209,544	$19,000	$22	53%
Phoenix	Washoe	2,258	48%	$783,846	$72,000	$32	49%
Phoenix	Yerington	655	55%	$111,007	$10,000	$15	55%
Phoenix Total		**136,431**	**51%**	**$36,334,947**	**$3,359,000**	**$25**	**52%**
Portland	Burns Paiute	230	127%	$0	$0	$0	127%

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Portland	Chehalis	856	46%	$364,073	$34,000	$40	47%
Portland	Coeur D'Alene	3,173	51%	$748,313	$69,000	$22	52%
Portland	Colville	7,531	52%	$1,430,143	$132,000	$18	53%
Portland	Coos, L Umpqua, Suislaw	482	91%	$0	$0	$0	91%
Portland	Coquille	633	79%	$0	$0	$0	79%
Portland	Cow Creek	905	58%	$57,744	$10,000	$11	58%
Portland	Grand Ronde	3,465	57%	$291,845	$27,000	$8	57%
Portland	Hoh	77	60%	$0	$0	$0	60%
Portland	Jamestown S'Klallam	336	66%	$0	$0	$0	66%
Portland	Kalispel	437	35%	$307,284	$28,000	$64	38%
Portland	Klamath	2,478	59%	$74,672	$10,000	$4	59%
Portland	Kootenai	166	86%	$0	$0	$0	86%
Portland	Lower Elwha	851	53%	$164,568	$15,000	$18	54%
Portland	Lummi	4,569	48%	$1,335,791	$123,000	$27	49%
Portland	Makah	1,902	50%	$509,789	$47,000	$25	51%
Portland	Muckleshoot	2,934	29%	$2,407,577	$222,000	$76	32%
Portland	Nez Perce	3,727	64%	$0	$0	$0	64%
Portland	Nisqually	910	59%	$26,975	$10,000	$11	59%
Portland	Nooksack	976	43%	$502,140	$46,000	$47	44%
Portland	Nw Band Of Shoshoni	205	61%	$0	$0	$0	61%
Portland	Port Gamble	919	52%	$220,163	$20,000	$22	53%
Portland	Puyallup	7,469	58%	$261,596	$24,000	$3	59%
Portland	Quileute	556	52%	$123,844	$11,000	$20	53%
Portland	Quinault	2,558	66%	$0	$0	$0	66%
Portland	Samish	144	122%	$0	$0	$0	122%
Portland	Sauk-Suiattle	138	133%	$0	$0	$0	133%
Portland	Shoalwater Bay	308	136%	$0	$0	$0	136%
Portland	Shoshone-Bannock	5,883	61%	$0	$0	$0	61%
Portland	Siletz	4,727	47%	$1,398,629	$129,000	$27	49%
Portland	Skokomish	931	57%	$75,354	$10,000	$11	58%
Portland	Spokane	2,676	52%	$540,410	$50,000	$19	53%
Portland	Snoqualmie	501	8%	$772,458	$329,000	$657	30%
Portland	Squaxin Island	746	67%	$0	$0	$0	67%
Portland	Stillaguamish	177	86%	$0	$0	$0	86%
Portland	Suquamish	494	79%	$0	$0	$0	79%

FY 2000 FDI: Table 8 -- IHCIF Distribution

FY 2001 Distribution of the $40 Million IHCIF

Area	Local Operating Unit	Users	FEHBP %	To get to 60%	IHCIF Allocation	IHCIF / User	Revised %
Portland	Swinomish	1,079	51%	$280,885	$26,000	$24	52%
Portland	Tulalip	3,472	36%	$2,118,301	$196,000	$56	39%
Portland	Umatilla	2,885	63%	$0	$0	$0	63%
Portland	Upper Skagit	420	52%	$87,335	$10,000	$24	53%
Portland	Warm Springs	4,695	85%	$0	$0	$0	85%
Portland	Yakama	11,988	51%	$2,539,469	$234,000	$20	51%
Portland	Western Oregon (Chemawa)	2,844	40%	$1,518,806	$140,000	$49	42%
Portland Total		**92,451**	**55%**	**$18,158,165**	**$1,952,000**	**$21**	**56%**
Tucson	Tonono O'Odham	18,778	51%	$3,572,891	$330,000	$18	52%
Tucson	Yaqui	4,833	67%	$0	$0	$0	67%
Tucson Total		**23,611**	**50%**	**$3,572,891**	**$330,000**	**$14**	**51%**
Grand Total		**1,428,118**	**50%**	**$426,273,940**	**$40,000,000**	**$28**	**51%**

These results include the following revisions to the methodology since the 2/14/2001 draft was released:

1) Discounted facility value (depreciation) by the cost to correct facility deficiencies;
2) Excluded patient transport costs ($34m in lower 48 and $32m in Alaska);
3) Excluded 12.5% of shares in all operating units consistent with CSC exclusions;
4) 4 OUs in Navajo, 2 in Phoenix, and 1 in Albuquerque Areas were broken out from previously consolidated service units;
5) Included "crossover" funding adjustments between Albuquerque, Navajo, Phoenix and Tucson Areas (debits and credits net to zero);
6) Included additional Non-CHSDA users which are proportionately identified by operating unit;
7) Revised data for a some OUs including purchase percentage and cost index based on an average of counties served;
8) Corrected FY 2000 financial data for some operating units including some documented exclusions;
9) Adjusted allocations to assure a minimum of $10,000 for any qualifying operating unit below 60%;
10) Rounded draft allocations to the nearest $1,000.
11) Adjusted allocations to insure a 30% minimum.
12) Reinstated a poverty index weighted at 1/3 and the health status index at 2/3.
13) Discounted the flat estimate of other resources by half for OUs that do not delivery billable services.
14) Changed named from LNF to FEI (FEHBP Equivalence Index) to accurately describe the methodology and reduce misunderstanding.

Tab B

Guidance for FY 2001 $40 Million IHCIF

This guidance for utilization of funds was issued with the formal funds allowances to IHS Area directors.

April, 2001

FOR PUBLIC RELEASE

GUIDANCE For FY 2001 $40 MILLION IHCIF

Allocation Methodology for FY 2001

The Director, IHS has decided to adopt the Indian Health Care Improvement Fund (IHCIF) allocation recommendations from the Workgroup with certain exceptions. The attached April 17, 2001 decision memo shows the Director's decisions on the IHCIF allocation methodology. The decision memo explains the modest changes to the formula since the March 6-7, 2001 Consultation Forum held in Albuquerque, NM. All data and calculations for the FY 2001 IHCIF allocation are posted on the IHS website.

Distribution Tables

Tables showing the IHCIF distribution among all IHS Areas are attached to the allowance transmittals. Local units within each IHS Area are listed in the second column labeled "Operating Unit". Amounts for qualifying units are listed in the 6th column labeled "IHCIF Allocation". Please be aware that units above the 60% LNF average receive no IHCIF funds in FY 2001. Operating units qualifying for IHCIF in FY 2001 receive only 9.2% of funds needed to get to the 60% level. With this approach, more funds go to operating units with the lowest funding percentages.

Distribution Among Units Within the IHS Area

Not all units identified in the table are self-contained units. The national application of the allocation methodology may incompletely account for certain complexities and variations in and among local level operating units. The Area Office, after consultation with affected parties, may distribute IHCIF operating unit funds among the constituent parts of operating units or among relevant operating units based on actual service usage patterns or similar equitable measures consistent with the governing language in section 1621 of the Indian Health Care Improvement Act. Language governing distribution of IHCIF funds specifies distribution criteria based on "health status and resource deficiency" taking into account "cost of providing health care services given local geographic, climatic, rural, and other considerations."

Purpose and Use of Funds (Section 1621 of Indian Health Care Improvement Act)

The Secretary is authorized to expend funds which are appropriated under the authority of this section, through the Service, for the purposes of -

(1) eliminating the deficiencies in health status and resources of all Indian tribes,

(2) eliminating backlogs in the provision of health care services to Indians,

(3) meeting the health needs of Indians in an efficient and equitable manner, and

(4) augmenting the ability of the Service to meet the following health service responsibilities, either through direct or contract care or through contracts entered into pursuant to the Indian Self-Determination Act (25 U.S.C. 450f et seq.), with respect to those Indian tribes with the highest levels of health status and resource deficiencies:

(A) clinical care (direct and indirect) including clinical eye and vision care;

(B) preventive health, including screening mammography in accordance with section 1621k of this title;

(C) dental care (direct and indirect);

(D) mental health, including community mental health services, inpatient mental health services, dormitory mental health services, therapeutic and residential treatment centers, and training of traditional Indian practitioners;

(E) emergency medical services;

(F) treatment and control of, and rehabilitative care related to, alcoholism and drug abuse (including fetal alcohol syndrome) among Indians;

(G) accident prevention programs;

(H) home health care;

(I) community health representatives; and

(J) maintenance and repair.

Recurring Distribution

The Director, IHS has decided to distribute the $40 million IHCIF on a **recurring** basis beginning with FY 2001. The IHS will annually assess and update the IHCIF allocation formula in subsequent years as additional IHCIF funds are appropriated.

Tab C

February 13, 2001, letter of recommendations from the LNF Workgroup

This 7 page letter provides context for the LNF methodology, recommended changes and improvements to the LNF methodology based on comments offered during 3 regional consultation forums, and a series of concerns that the LNF Workgroup urges the IHS to address.

April, 2001

February 13, 2001

Dear Dr. Trujillo;

In your August 28, 2000 letter to tribal leaders, you stated that the Level of Need Funded (LNF) Workgroup was "to continue refining a methodology for the Indian Health Care Improvement Fund that considers the feedback from tribes and Indian health leaders." Members of the LNF Workgroup have participated in three regional consultation forums to hear directly from tribal leaders and also have reviewed more than a hundred letters and position papers from tribes. Following the consultation forums, the Workgroup met February 6-8 in Denver, Colorado to discuss the tribal views and to propose revisions to the LNF methodology accordingly. This letter contains our recommendations for improving the LNF methodology and the related resource allocation formula.

Before outlining our proposals, it is appropriate to briefly review the history of the LNF issue as a means of placing in context our recommendations concerning the FY 2001 Indian Health Care Improvement Fund (IHCIF).

BACKGROUND

The provision of a broad scope of health and public health services to the American Indian and Alaska Native (AI/AN) Tribes is a continuing responsibility of the U.S. government. Historically, these services have been provided through annual discretionary funding provided to the Indian Health Service (IHS). Over the past thirty years there has developed a chronic pattern of under funding. In recent years, the Congress has failed to provide sufficient funds to address even natural population growth and medical inflation. The resulting erosion of buying power has contributed to the disparity in health status among AI/AN communities.

In 1992 the Congress attempted to address this situation through the enactment of Section 1621 of the Indian Health Care Improvement Act, which authorized the IHCIF for "eliminating the deficiencies in health status and resources of all Indian tribes". Sadly no funds were appropriated to the IHCIF until eight years later. In December 1998 you created the LNF Workgroup and assigned to us the responsibility to develop a methodology to identify the health status and resource deficiency for each Indian tribe as required in the Act.

In developing the methodology, the Workgroup has tried to uphold core principles of comparability and credibility based on objective data. Fundamentally, the LNF methodology makes an "apples to apples" comparison between the cost of service provided to the IHS active users and the cost of services provided by the Federal Employees Health Benefit Package, a mainstream health plan available to federal employees through out the nation. This comparison addresses personnel health care services, the core activity of the agency, but not the full scope of IHS services which

include critical public health, environmental, and community sanitation programs. The approach we selected is based on an actuarial analysis of the IHS active user population that seeks to identify health care funding for AI/AN that is comparable to other Americans of similar age and health characteristics.

In FY 2000, Congress appropriated $10,000,000 in the IHCIF. This is contrasted to a national IHS shortfall $1.3 billion that we identified in our Phase I LNF Report. The Congress also directed the IHS to use the LNF methodology to distribute the IHCIF fund. Although the Phase I LNF Report was widely hailed for identifying the high level of under funding using scientific methods, many tribal leaders also felt that the allocation formula, which is based on funding deficiencies identified by the LNF methodology, was not sufficiently tested to justify a recurring distribution of the $10,000,000 and suggested further refinements.

In response to this situation, the Congress appropriated an additional $30,000,000 in the IHCIF for FY 2001 and directed the IHS to continue to work with the Tribes to refine the formula. Subsequently, three regional consultation meetings were held for the purpose of collecting an extensive list of adjustments and improvements to the LNF methodology. The Workgroup discussed this list extensively on February 6-8, 2001 at our meeting in Denver, Colorado. Our discussions have resulted in a series of revisions to the methodology for your review and subsequent review by tribal leadership at a National Consultation Meeting scheduled for March 6-7, 2001 in Albuquerque, New Mexico. It should be noted that several of the key decisions reflect a continuing division of opinion and that some concerns will require further review and analysis as part of the annual iterative process of LNF update and review.

REVISIONS TO THE LNF RESOURCE ALLOCATION FORMULA

Taken together, all of the recommended revisions produce moderate changes in results compared to FY 1999. ***Please note that estimates cited here and in attachments are approximate and may change as data are finalized in the next few weeks.***

For FY 2000, the revised LNF methodology identifies $3.5 billion needed to assure personal health care services to IHS active users that are comparable to those available to federal employees, an increase of $400 million over the estimate for FY 1999. The IHS funds available for personal medical services identified in FY 2000 are $1.8 billion, which is essentially unchanged from FY 1999. The resulting LNF percentage for IHS in FY 2000 is 51%, down from 57% in FY 1999. These results primarily are due to 2% more Indian users and 8% higher medical costs and the exclusion of additional IHS funds for wrap-around programs. Even though the overall IHS budget increased in FY 2000, extensive tribal comments identified substantial amounts of funds that were counted for personal medical services in FY 1999 that should have counted for "wrap-around" programs instead. For instance, the revisions for FY 2000 exclude 63% of contract support costs, more than $60 million for patient travel costs, and $36 million for the Community Health Aids Program in Alaska.

Based on the methodology as we have revised it, we estimate that an additional $1.7 billion is needed to fund IHS and tribal operating units at a level comparable to the Federal Employees Health Benefits Plan. It would require an appropriation of $51 million to bring the lowest funded operating units up to 40% and an additional $352 million to bring all operating units up to the 60% level.

The LNF methodology that we recommend contains the following revisions:

1. The LNF benchmark cost per person was $2,980 in 1999. The benchmark for FY 2000 is increased to $3,221 per person consistent with an 8.1 percent increase in the cost of mainstream employer sponsored insurance plans. This adds $343 million to funding needs.

2. The FY 1999 methodology was based on 180 operating units. The number of separate operating units increased to 236 in FY 2000. This change is due to the breakout of operating units in Alaska, Portland, and Phoenix Areas, which had been grouped inappropriately as a collection of tribes in FY 1999.

3. A baseline count of 1.4 million active users was determined from FY 1998 IHS user counts. The workgroup had strongly preferred 1999 user counts. But these are unavailable due to continuing tabulation and verification problems.

4. The workgroup included 25,000 additional active users who, according to IHS data reside within IHS Area boundaries and regularly obtain services at an IHS or tribal health care facility, but were not counted as active users in FY 1999 because they live outside Contract Health Service Delivery (CHSDA) boundaries. This adds $80 million to funding need.

5. Additional data items were obtained directly from IHS and tribal operating units in FY 2000. The purpose was to identify more accurate price indices for purchased medical services based on actual patient referral patterns. New data submitted by the operating units include:

    a. The percentage of medical services that are purchased
    b. The location for primary care referrals
    c. The location for specialty care referrals
    d. The price indices for primary and specialty referral locations are averaged in the LNF model

6. The workgroup set a floor medical price index for purchased medical services. We believe extremely low price index values, which are typical in some rural areas, are unrealistic for the Indian health programs. After applying the floor and related data calibrations among all 236 operating units, the lowest purchase price index actually assigned any operating unit is 91% and the highest value assigned any operating unit in the lower 48 states is 123% of the national average.

7. The workgroup declined to increase the average price adjustment for Alaska above 138% that was approved in FY 1999. For FY 2000, 125% is applied to operating units in the Anchorage region and 148% is applied to other Alaska locations to maintain the 138% statewide average. The Alaska LNF workgroup representative has submitted a dissenting opinion on this item. In recognition of the isolation of 229 villages throughout remote areas of Alaska, $36 million of costs for the Alaska Community Health Aid program is excluded as wrap-around. Similarly, the workgroup excluded additional patient transport costs in Alaska up to a maximum of $32 million based on validated costs.

8. The workgroup reaffirmed a cost adjustment in the IHCIF formula to be applied to internal costs based on size of the operating unit. The adjustment is premised on better cost efficiency for larger operating units and lower cost efficiency for smaller operating units. Internal costs are the costs of providing personal health care services to active users with the internal workforce of the operating unit as contrasted to the costs of purchasing those services externally. The cost adjustment ranges from a low of 87.5% for the largest operating unit to a high of 130% for all operating units with less than 900 users.

9. The workgroup is replacing the health status index used in methodology in FY 1999. In the formula, the health status index adjusts needed funding for the varying disease burden as measured among IHS areas. The new health status index for FY 2000 is composed of the following factors:
    a. 15% for birth disparities (low and high birth weight infants)
    b. 75% for disease disparities based on excessive rates of injuries, heart disease, diabetes, cancer, and alcoholism among the Indian population
    c. 10% for number of users older than 54 years of age
    d. If the disease rate was an extreme low outlier, due to incomplete identification of Indians in various data sources, the workgroup substituted the data rate observed of the next closest IHS area rate.

    The new health status index adds costs that range from $1,017 per user for operating units in the Area with lowest health status index to $525 per user in the Area with the highest health status index. The average adjustment is $644 per person for low health status among Indians compared to other Americans (e.g., without a health status adjustment, the benchmark cost would be $2,577 per active user rather than $3,221 per active user).

10. The workgroup excludes 63.4% of Contract Support Costs (CSC) based on a technical workgroup analysis. The exclusion is required to maintain internal equity between direct service programs and self-determination programs. This excludes $134 million for self-determination programs due in part to certain unique costs for tribal contracts/compacts that are not required of Federal programs and in part to higher costs experienced by tribes when they operate health delivery programs independent of the Federal system. Similarly, 63.4% of the 20% portion of headquarters and area office tribal shares related to CSC type

costs are also excluded for both direct service and self-determination programs.

11. Depreciation for federally funded hospitals and clinics that are under 30 years of age is counted as an available resource. If the balance of facility assets is less than the cost to correct facility life and safety code violations, no depreciation is counted. Depreciation that was funded with Maintenance and Improvement funds, which already are counted in the formula, will not be double counted.

12. A $745 discount for coverage from other sources (Medicaid, Medicare, and Private Insurance) was applied in FY 1999. This amount is inflated by 6% to $790 for FY 2000 based on national average increase in Medicaid expenditures.

13. Efforts to improve the accuracy of financial data for individual operating units were instituted for FY 2000. Foremost among these is the itemization of tribal shares for IHS headquarters and Area offices to avoid duplicate counting. This is one reason for more accurate accounting of available resources counted towards personal health care services versus wrap-around programs.

14. The workgroup considered several allocation formula options for FY 2000 including a tiered allocation among all operating units with less than 100% of need. It approved a formula that targets allocations to operating units that are funded at less than 60% of need. This policy is consistent with the approach in FY 1999 and with Congressional direction to focus Indian Health Care Improvement funds to tribes that are "most in need".

15. The Congress urged consideration for a minimum allocation to operating units qualifying for IHCIF funds. The workgroup set a minimum of $10,000 per operating unit for any IHCIF allocation.

16. The workgroup reaffirmed that $40,000,000 in the Indian Health Care Improvement Fund ($10,000,000 from FY 2000 IHS appropriation plus $30,000,000 from the FY 2001 IHS appropriation) be allocated to local operating units by formula in FY 2001 and that such allocations be made recurring to the operating unit in years thereafter.

17. The workgroup reaffirmed the need for continuing review and improvement of the LNF methodology on an annual basis. This may include additional actuarial studies to revise or replace the existing price benchmark.

CONTINUING ISSUES OF CONCERN

There is a list of serious and in some cases long standing issues of concern that the IHS is urged to address as quickly as possible. The most troubling of these concerns is the continuing failure of the IHS to produce unduplicated active user counts in a timely manner. Although the Workgroup recognizes that the IHS has made considerable efforts over the past two years to improve data collection systems, these efforts have yet to

accomplish their goal. Sufficient resources must be marshaled at all levels to overcome these problems.

A consistent theme heard in all three regional consultation meetings is the need for a rigorous data driven formula to identify funding needs for public health, outreach and environmental health services not addressed in the LNF methodology. We urge you to charge a workgroup to develop a methodology for wrap-around programs this year.

A significant portion of the tribal leaders who participated in the regional consultation meetings expressed opinions that the LNF methodology should not include third party coverage available to Indian people including Medicaid, Medicare, private health insurance and the new Children's Health Insurance Program. This opinion is driven in part by a feeling that increased reliance on these funding sources represents a rollback of the federal trust responsibility to Indian Tribes. Another reason expressed is that access to health care for Indian people should not be subject to means testing. Inclusion of these resources in the LNF methodology, however, is responsive Congressional directives established in statute in Section 1621 of the Indian Health Care Improvement Act. The Workgroup urges that you communicate as forcefully as possible to the new Administration the critical role that the IHS plays in providing access to heath services and coverage to the Indian community.

The Health Care Financing Administration is the second largest funding source for health care services to the Indian community through its Medicaid, Medicare and S-CHIP programs. This activity has created a large body of encounter level data on health care services to AI/AN. Unfortunately there is a high level of misidentification of Indian Tribal status in this database. The IHS active user data set clearly identifies the Indian population that depends on the IHS as its primary health care provider. Matching these two data sets would provide the information to more fairly identify third party coverage by operating unit. And, perhaps more importantly, it would provide the encounter level information necessary to update the cost benchmark for personal medical services. The Workgroup urges you to establish the necessary collaboration with HCFA to carry out this research.

In the past several years, a significant number of tribes and health programs have responded to the lack of federal facility construction funding by entering into long-term debt to finance replacement of old and inadequate health care facilities. An extensive study done by the National Indian Health Board has documented the importance of this trend to the viability of the IHS funded health care delivery system. Servicing construction debt is generally accomplished through a long-term commitment of third party income, which would otherwise be available for the provision of health care services to tribal members. The task group recommends that the IHS develop a national database that would identify any health facility financing costs incurred by tribes so that any debt payments may be discounted from the LNF methodology.

In FY 2000, the LNF Workgroup has included counts of AI/AN who live outside of designated Contract Health Service Delivery Areas (CHSDA) who regularly obtain direct

care services in IHS and tribal health facilities though they are ineligible for referral under CHS. This approach rightly identifies the financial burden of providing care to these persons. However, this expanded definition may exclude additional Indian users who reside in states that are not included in the twelve designated IHS Areas or who reside in counties designated as Urban Indian service areas. There is a similar concern related to "crossover" users who reside in one Area or operating unit and crossover to another Area or operating unit to receive a portion of their services. We recommend that the IHS develop a more precise system of patient registration and frequency of facility usage that more accurately accounts for the real financial burdens experienced by operating units where substantial cross-over utilization occurs.

The LNF methodology is an actuarial based method of resource planning and distribution. It relies on techniques long used by both private industry and other governmental programs to calculate resource requirements. The LNF Workgroup recommends that the IHS further integrate the LNF approach into its budget development and justification activities. The identification of a $1.7 billion shortfall in IHS funding for personal health care services for fiscal year FY 2001 is solid evidence of a historic under funding of health care for Indian people.

For the past two years the LNF Workgroup has struggled with the problem of identifying an appropriate cost index for health care services provided in the Alaska Area. The vast size of that Area, the extreme remoteness and dispersion of much of its service population and the unique delivery system that has evolved there complicates the assessment of need in that Area. Most of Alaska is best understood as being outside of the experience of normal health care markets and, as a consequence, cost/price data comparable to that in the lower 48 states are rarely available in Alaska. At the recent Denver LNF Workgroup meeting, three proposals to adjust the LNF model for unique Alaska costs were considered. Although the Workgroup approved two of these proposals, it rejected the third by a narrow margin of opinion. A formal note of dissent from this action by the Alaska delegate is attached for your review. It is perhaps inevitable that the cost of care in Alaska will continue to be a divisive issue, which will require additional research, discussion, and possible adjustments.

We have attached initial results from the revised LNF model for your review and consideration. ***Again, please be aware that the attached draft results are for consultation purposes and may change before the March consultation meeting due to certain data refinements now underway.*** We look forward to meeting with you and the Tribal Leaders at the national Tribal Consultation meeting scheduled for March 5-9, 2001 in Albuquerque, New Mexico.

James Allen Crouch
Tribal Co-Chair, LNF Workgroup

Cliff Wiggins
IHS Co-Chair, LNF Workgroup

Enclosures

Tab D

Director's Decision Memo for the FY 2001 IHCIF

April, 2001

April 17, 2001

TO: Director

FROM: Senior Operations Research Analyst

SUBJECT: Distribution of fiscal year (FY) 2001 Indian Health Care Improvement Fund--ACTION

ISSUE

The Congress appropriated $30 million in FY 2001 for the Indian Health Care Improvement Fund (IHCIF). To this amount is added $10 million that was distributed non-recurring in FY 2000. This memo recommends for your approval a methodology for distributing the $40 million total for FY 2001.

DISCUSSION

In your August 28, 2000 letter to tribal leaders, you stated that "I have decided to distribute the $10 million IHCIF on an interim basis while continuing consultation to finalize a permanent methodology to apply in FY 2001 and afterwards." You asked the Level of Need Funded (LNF) Workgroup to continue working to finalize a methodology that considers the views of tribes and Indian health leaders.

Since August 28, 2000, the IHS together with the LNF Workgroup has conducted extensive additional tribal consultation including three regional forums and a national forum. Many tribal and Indian health care leaders attended the consultation forums and proposed a variety of modifications and refinements to the allocation methodology. The LNF Workgroup met to review the tribal input and to adopt modifications and refinements to the methodology accordingly. The LNF Workgroup sent a letter to you on February 13, 2001 containing its recommendations for refining the methodology for the FY 2001 IHCIF distribution.

Attachment A shows the proposed FY 2001 IHCIF distributions based on the recommendations below. Attachment B shows a series of charts that illustrate the numerical results. Please indicate your support for the recommendations by initialing on the "Approved" line.

RECOMMENDATION 1

I am conveying the request of the LNF Workgroup that you accept the allocation methodology recommendations contained in the February 13, 2001 letter (attachment C) from the LNF Workgroup ***except as modified by subsequent recommendations below.***

APPROVED APPROVED DISAPPROVED_____ Date_____

RECOMMENDATION 2

Given the

- evidence of links between underlying poverty conditions, lack of access, and poor health status, and
- consistent with strong expressions by many tribal leaders to put low health status, poverty, and lack of economic opportunity in the forefront of federal policy making for Indian country,

therefore, reinstate a poverty measure in the health status section of the allocation methodology. Combine the poverty index with the health status index recommended by the Workgroup by weighting the poverty index at 1/3 and the health status index at 2/3. The poverty index shall include the extent that poverty among American Indians and Alaska Natives (AI/AN) exceeds the rate of US All Races (a measure available only for IHS areas) and a measure of the prevailing poverty rate in counties served by each operating unit.

APPROVED APPROVED DISAPPROVED_____ DATE_____

RECOMMENDATION 3

Given evidence that a limited number of operating units that do not provide billable health care services cannot obtain collections for patients eligible for Medicare, Medicaid or private insurance coverage,

therefore, discount the flat rate estimate for other resources in the methodology from $797 per user to $399 per user for operating units that are more than 85% reliant on Contract Health Services. The discount is not 100% because these operating units still benefit from cost avoidance when their Medicare, Medicaid and private insurance eligible patients obtain care elsewhere.

APPROVED APPROVED DISAPPROVED_____ DATE_____

RECOMMENDATION 4

Given that

- $40 million available in FY 2001 is far short of the $1.7 billion deficiency compared to costs of equivalent services defined in the benchmark Federal Employees Health Benefit Plan (FEHBP) and
- priorities for allocating the limited available funds must be identified and
- section 1621(a)4 of the Indian Health Care Improvement Act requires the Indian Health Service (IHS) to address deficiencies for "…those Indian tribes with the highest levels of health status and resource deficiencies",

therefore, distribute FY 2001 IHCIF funds to operating units currently funded at less than 60 percent. Because $40 million is insufficient to eliminate resource deficiencies at the 60 percent level, distribute FY 2001 IHCIF funds in proportion to the deficiency of each qualifying operating unit, e.g., more funds to operating units with lower percentages.

APPROVED 

DISAPPROVED_____ DATE_____

RECOMMENDATION 5

Consistent with support expressed during consultation forums to help operating units with the most extreme resource deficiencies,

therefore, distribute the FY 2001 IHCIF in a manner to insure that every operating unit is funded at no less than 30 percent as measured by the methodology in FY 2001.

APPROVED 

DISAPPROVED_____ DATE_____

RECOMMENDATION 6

Because

- the national application of the allocation methodology may incompletely account for certain complexities and variations in and among local level operating units, and
- section 1621(b)2a of the Indian Health Care Improvement Act requires that "…funds allocated to each service unit… shall be used to reduce the health status and resource deficiency of ***each tribe*** served by such service unit",

therefore, the Area Office, after consulting with affected parties, may distribute IHCIF operating unit funds among the constituent parts of operating units based on actual service usage patterns or similar equitable measures.

APPROVED 

DISAPPROVED_____ DATE_____

RECOMMENDATION 7

Given the

- refinement in the allocation methodology produced by extending consultation since August 28, 2000 and
- consistent with many proposals for maintaining stable funding for critically needed health services,

therefore, the FY 2001 IHCIF distribution to operating units shall be ***recurring*** to the operating units in years thereafter.

APPROVED 

DISAPPROVED_____ DATE_____

RECOMMENDATION 8

Given that

- the current methodology defines an actuarial cost benchmark for assuring personal health care benefits to IHS users that is equivalent to the Federal Employees Health Benefits Plan (FEHBP) and
- critical "wrap around" IHS services such as clean water supply, safe waste disposal, public health activities, and community based health programs are not covered in the FEHBP and
- the term "Level of Need Funded" is regularly misunderstood to mean all needed and necessary funds, and
- the percentage cited in the current methodology for any operating unit is not a percentage of its true funding needs, but rather a percentage equivalence with the FEHBP,

therefore, change the name of the methodology from LNF to:

Option 1: **FEI** – **F**EHBP **E**quivalence **I**ndex. ____
Option 2: **FPI** - **F**EHBP **P**arity **I**ndex. ____
Option 3: **FDI** - **F**EHBP **D**isparity **I**ndex. APPROVED

APPROVED___APPROVED__ DISAPPROVED_____ DATE_____

Cliff Wiggins

Attachments

Tab E

Summary of Revisions to the Methodology for FY 2001

This 1 page summary identifies the major changes to the methodology since FY 2000 as recommended by the LNF Workgroup.

April, 2001

The Methodology for FY 2000

Element	Revision
Active Users	• Added 28,000 users residing outside CHSDA service area boundaries for a total of 1.428 million users. Future counts may decrease when an undetermined number of duplicates, estimated at 8%-12% in some locations, are cleared up.
$3,221 Per User Benchmark	• Inflated the FEHBP $2,980 benchmark premium by 8.1% to $3,221. 8.1% is the US average premium increase in employer sponsored health plans in 2000.
Variation for Size	• Reaffirmed a budget neutral variation of the $3,221 benchmark for size. The range is $2,818 for units with > 21,000 active users to $4,187 for units with < 900 active users.
Variation for Prices	• Reaffirmed a budget neutral variation for health care prices for actual referral locations. The range is $2,834 to $3,962 in the lower 48 states and up to $4,767 in Alaska.
Variation for Health Status	• Reaffirmed a budget neutral variation for health status. A new index is 2/3 disease burden (births, injuries, heart disease, diabetes, cancer, alcoholism and elderly) and 1/3 poverty. The range is $3,010 for best health health status to $3, 685 for lowest health.
- $790 Per User Other Coverage	• Statute requires counting other (M&M&PI) resources for Indians. $790, 6% higher, is deducted from the $3,221 benchmark. The deduction is 1/2 for operating units with no billable services.
Available IHS $ Per User	• Accounting for IHS funding was improved in FY 2000. Central funds, such as residual and area-wide programs, were prorated among units. IHS funds increased in 2000, but funds for benchmark type services is unchanged because of wrap-around exclusions.
Wrap-around Exclusions	• Using detailed accounting, 28% of IHS resources were identified as wrap-around, up 8% over 1999. The increase is composed of CSC (63%), the CHA/P (village aid program), and additional travel/transport expenses in Alaska.
FEHBP Equivalence %	• The % equivalence with the FEHBP decreased from 57% in 1999 to 50% in 2000. The change is caused by 2% more users, 8% higher premiums, and additional wrap-around funding exclusions.
60% IHCIF Threshold	• After considering several options, a threshold of 60% was set consistent with Congressional direction to target funds to "most under funded units." A $10,000 minimum was set for qualifying operating units.
Recurring Allocations	• Affirmed that the FY 2001 IHCIF ($40 million) is allocated by formula to local operating units and that local IHCIF allocations be made recurring thereafter.

Tab F

Summary of Regional Consultation Forums

This 1 page summary identifies issues most frequently raised during the three LNF regional and one national consultation forums. The complete proceedings for each regional forum are posted on the LNF website at:

WWW.IHS.GOV/NONMEDICALPROGRAMS/LNF

April, 2001

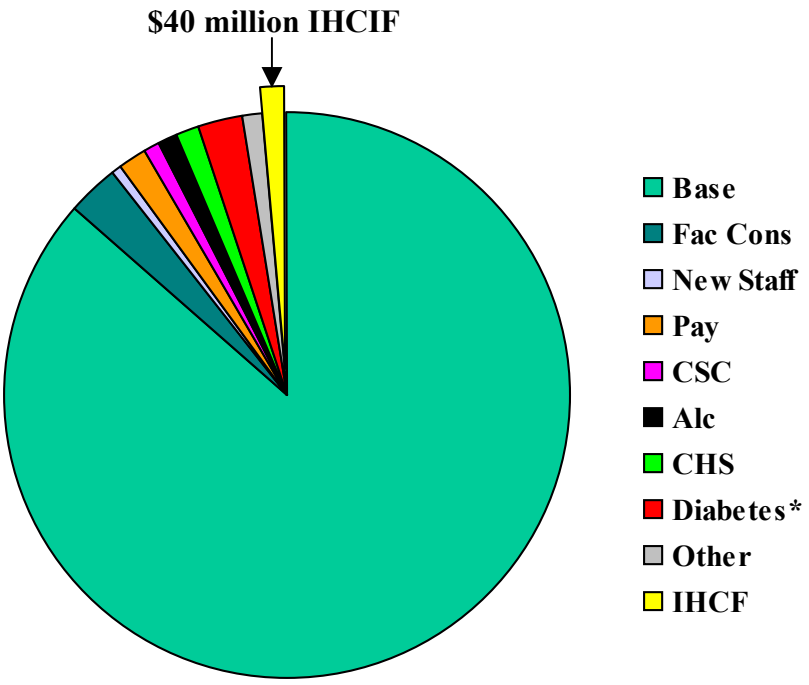
Summary of Regional Consultation Forums

- Comments both supporting and opposing the IHCIF formula were heard.
- There are a variety of views about the 60% threshold. Some proposed raising the threshold to 80% or 100% to include additional tribes in the distribution of funds. Others proposed lowering it to 40% to further concentrate funds for the most needy. Still others proposed a tiered or graduated approach. The Congress directed that funds go to the "most under funded units." The tradeoff is between concentrating funds to those most in need (a lower threshold) versus including a wider range of units (a higher threshold).
- The LNF methodology explicitly excludes infrastructure and "wrap-around" services. Both personal health services and "wrap-around" community health programs are important for raising health status of Indian people. IHS is proposing a new work group to develop a companion methodology for wrap-around programs. Many say that equity is not fully addressed until a companion wrap-around methodology is completed.
- Many suggest modifying the health status factor to focus on disease burden and disparities among Indian people and refining the IHCIF formula so that health status contributes more to results. After all, improving health status is the goal of IHS.
- Many oppose the global deduction of $745 for other health care resources as required in statute. Several concerns are raised. First, because health care is a federal responsibility based on treaties, counting other resources appears to roll back federal responsibility to tribes. Second, a single global amount will not reflect variations that may exist among local operating units. And, a number of tribal leaders link this issue with means testing principles which they oppose.
- Concerns regarding data consistency and quality were raised:
  - Active User Counts (gaps in data, unduplication of active users, and inclusion of users residing outside traditional service area boundaries)
  - Regional/local price variations (typical rural cost factors may understate true costs in remote areas)
  - Health Status Data (county level data is preferred if available and feasible)
- There were comments about the struggles to identify a fair cost index for Alaska. The vast size and distances, extreme remoteness, and a unique delivery system that has evolved there are cited. Most of Alaska is outside typical health care markets and cost/price data comparable to that from the lower 48 states is rarely available.
- Options were proposed to incorporate all or parts of the actuarial methodology to help formulate IHS budget requests.
- Identification of operating units based on the local delivery system was proposed as compared to service unit designations which may not reflect actual local practices.
- Fairness issues in counting Contract Support Costs were identified. Most support excluding all or part of CSC to maintain internal equity between direct service programs and self-determination programs.
- There was support to allocate the $40 million IHCIF at the earliest possible time. Most cite severe under funding and the needs for these funds. Others say it is important to distribute funds to the field before spring appropriations hearings.
- There are a variety of views about whether the $40 million IHCIF distribution in FY 2001 should be recurring or non-recurring.

Tab G

CHART SERIES

FY 2001
IHS
Appropriations

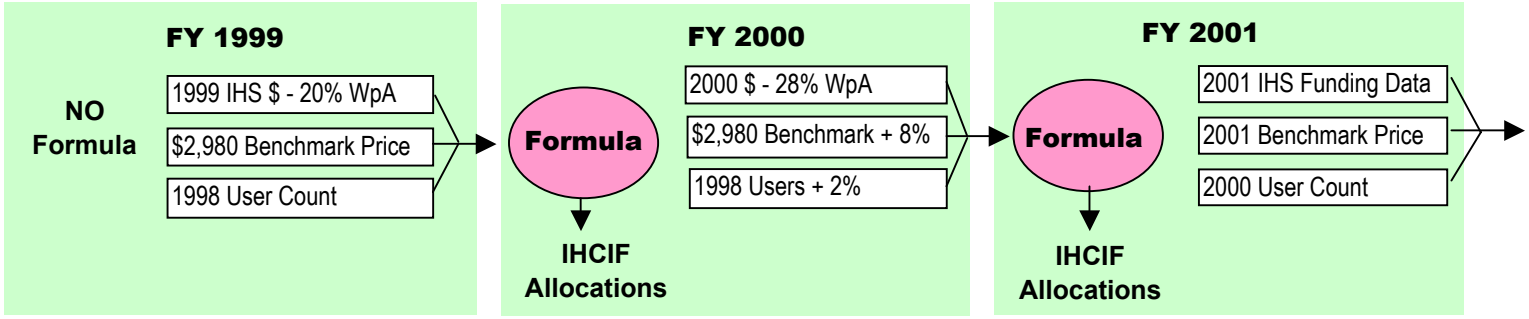


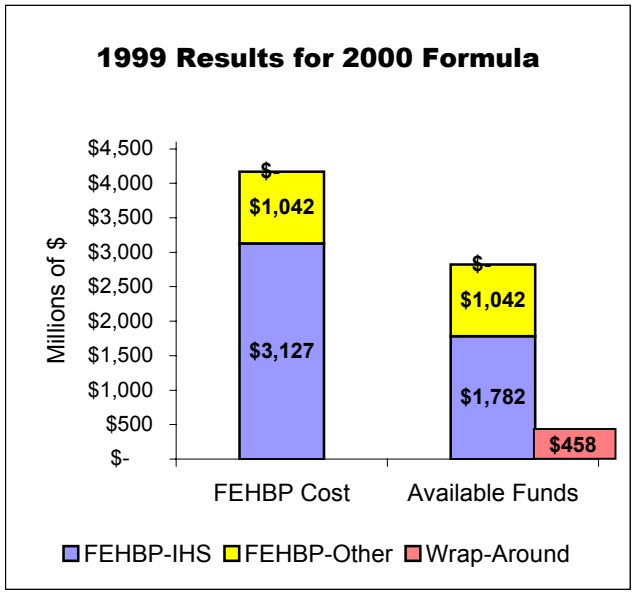
Pie Chart of FY 2001 IHS Appropriations

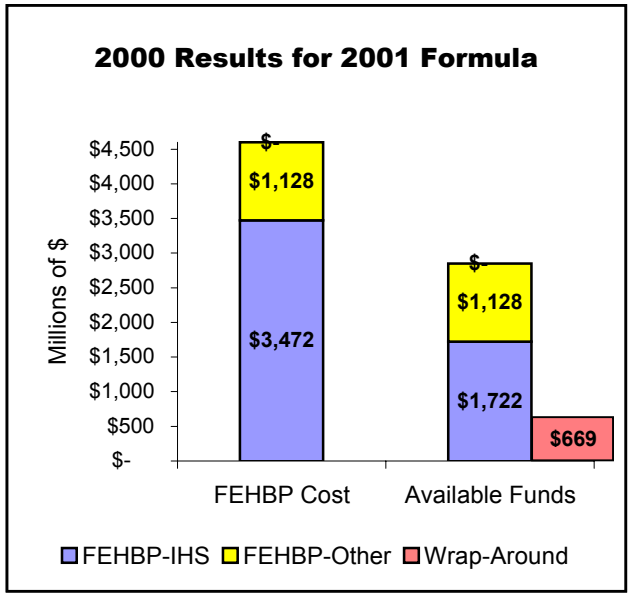
April, 2001

FDI Graphic A

Modest Changes to the Methodology in 2001







Changes to the Methodology

1. Premium rates for the benchmark plan increased 8%. + $275 million costs
2. 28,000 users from Non-CHSDA areas were counted for the first time (2%). + 70 million costs
3. 28% ($211 million more) of IHS funds were counted as "wrap-around" instead of for personal health care.

Chart 1

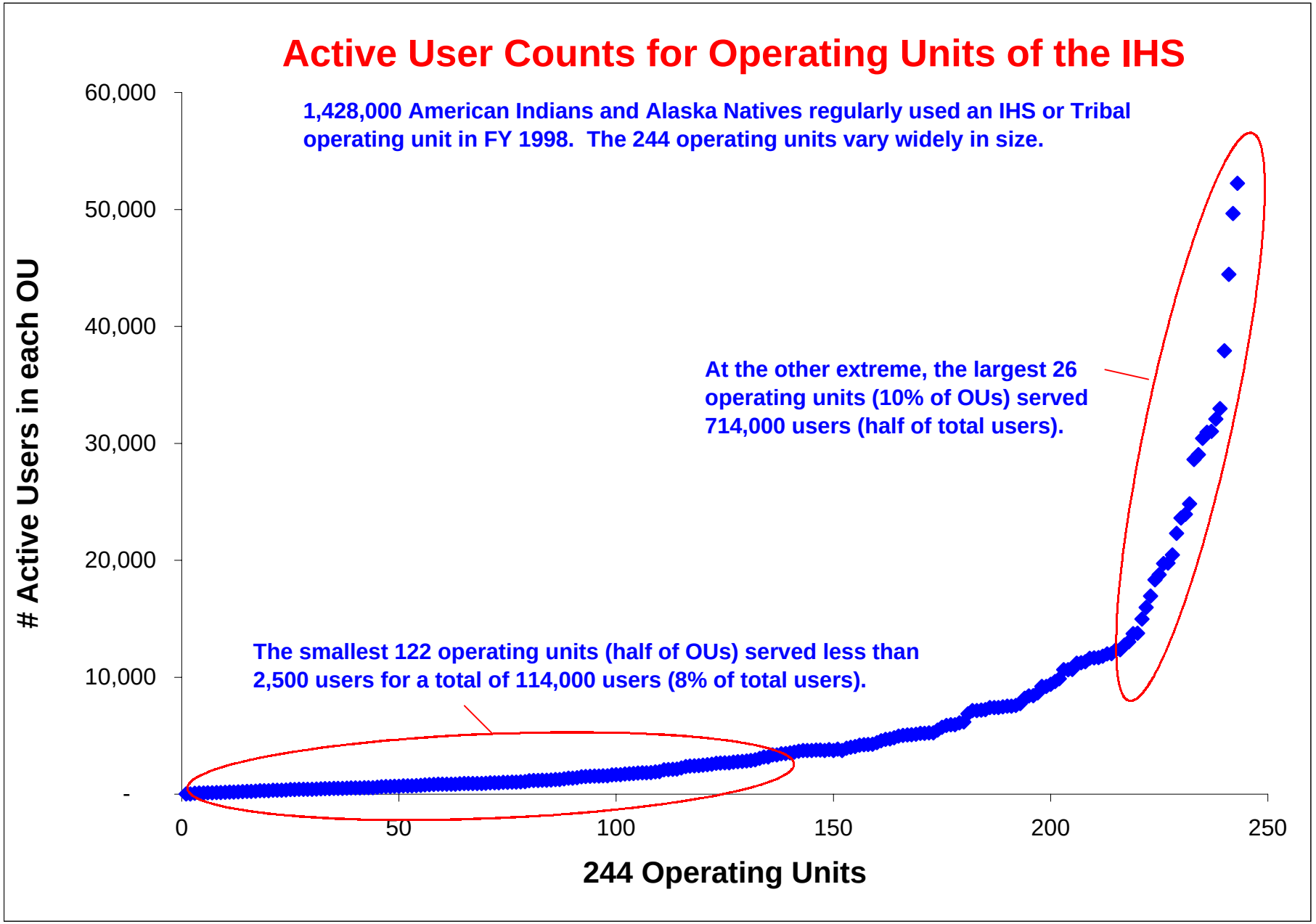

Active User Counts for Operating Units of the IHS
1,428,000 American Indians and Alaska Natives regularly used an IHS or Tribal operating unit in FY 1998. The 244 operating units vary widely in size.
At the other extreme, the largest 26 operating units (10% of OUs) served 714,000 users (half of total users).
The smallest 122 operating units (half of OUs) served less than 2,500 users for a total of 114,000 users (8% of total users).
Active Users in each OU
60,000
50,000
40,000
30,000
20,000
10,000
-
0
50
100
150
200
250
244 Operating Units

Chart 2

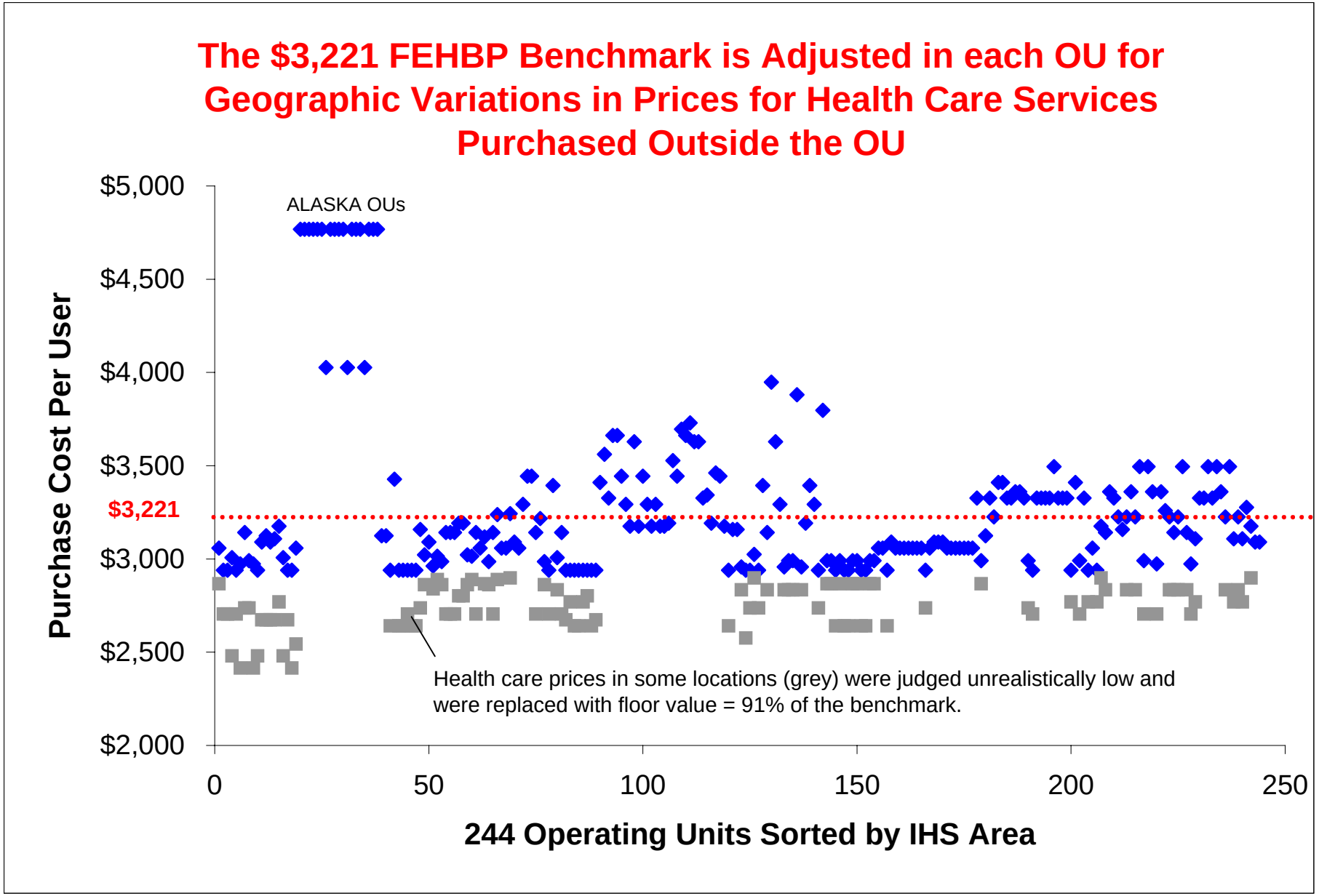
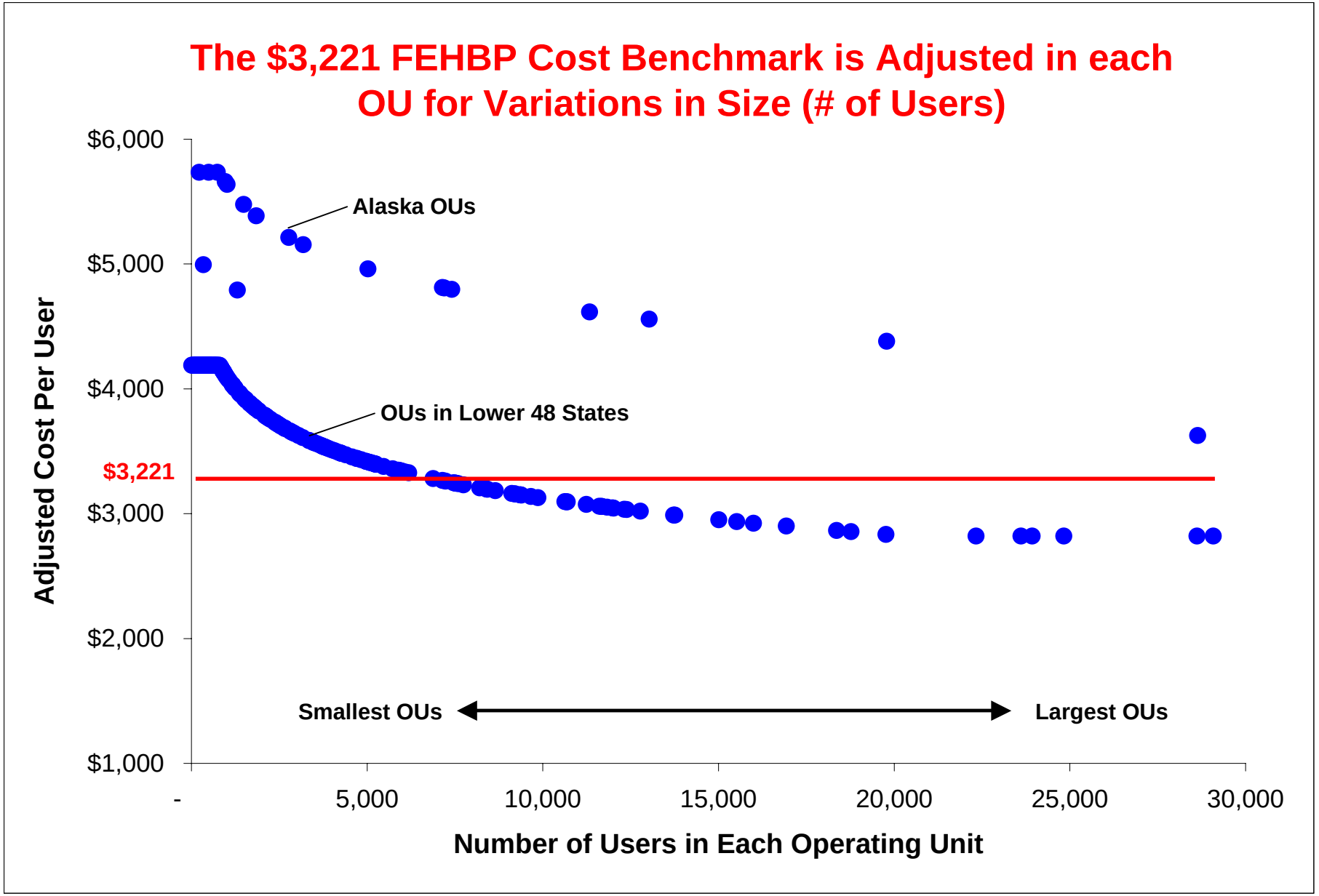

The $3,221 FEHBP Benchmark is Adjusted in each OU for Geographic Variations in Prices for Health Care Services Purchased Outside the OU
Purchase Cost Per User
$5,000
$4,500
$4,000
$3,500
$3,221
$3,000
$2,500
$2,000
ALASKA OUs
Health care prices in some locations (grey) were judged unrealistically low and were replaced with floor value = 91% of the benchmark.
0
50
100
150
200
250
244 Operating Units Sorted by IHS Area

Chart 3


The $3,221 FEHBP Cost Benchmark is Adjusted in each OU for Variations in Size (# of Users)
$6,000
$5,000
$4,000
$3,221
$3,000
$2,000
$1,000
Adjusted Cost Per User
Alaska OUs
OUs in Lower 48 States
Smallest OUs
Largest OUs
-
5,000
10,000
15,000
20,000
25,000
30,000
Number of Users in Each Operating Unit

The $3,221 FEHBP Benchmark is Adjusted in each OU for Variations in the Poverty Rate of Users

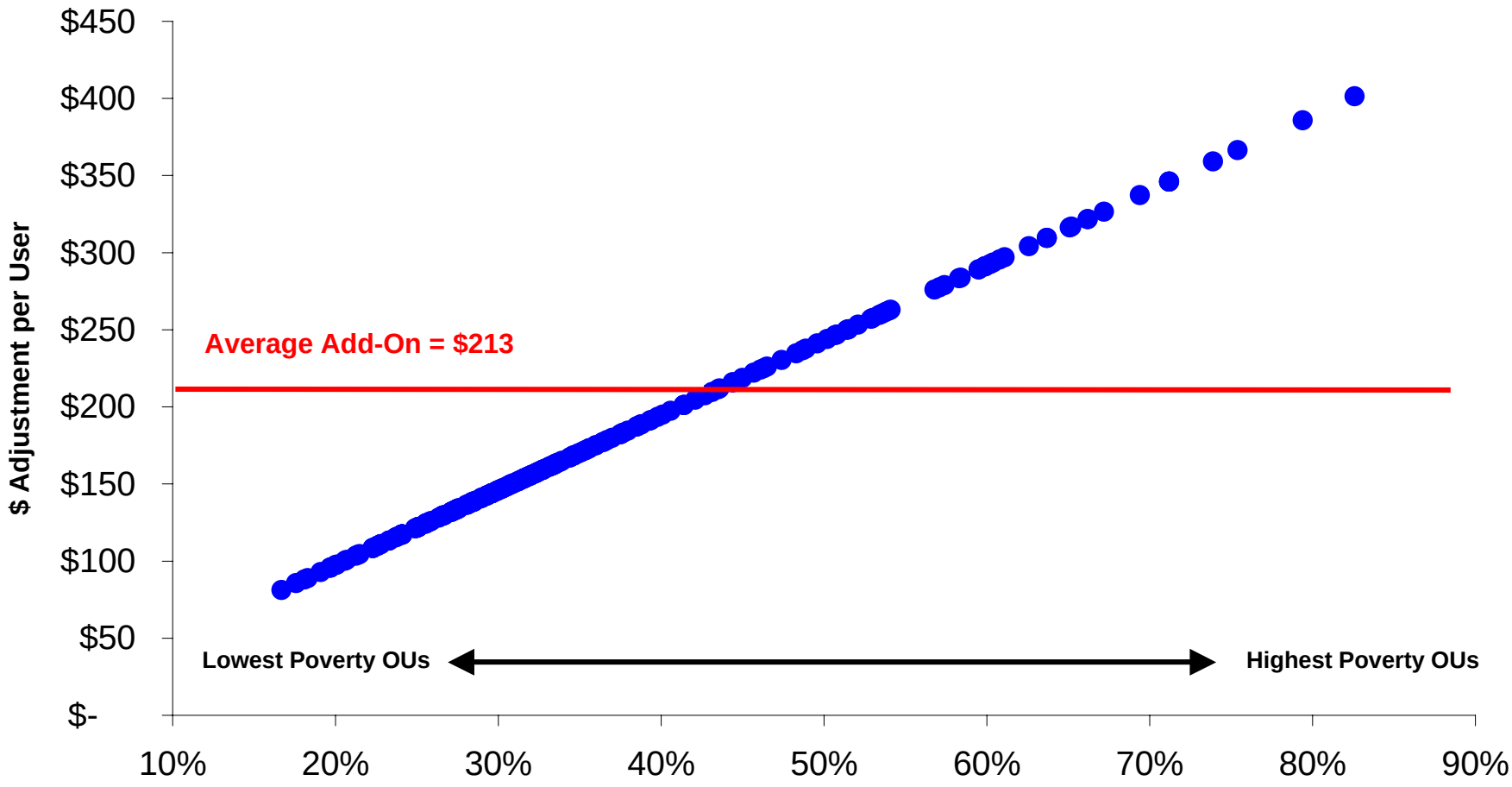
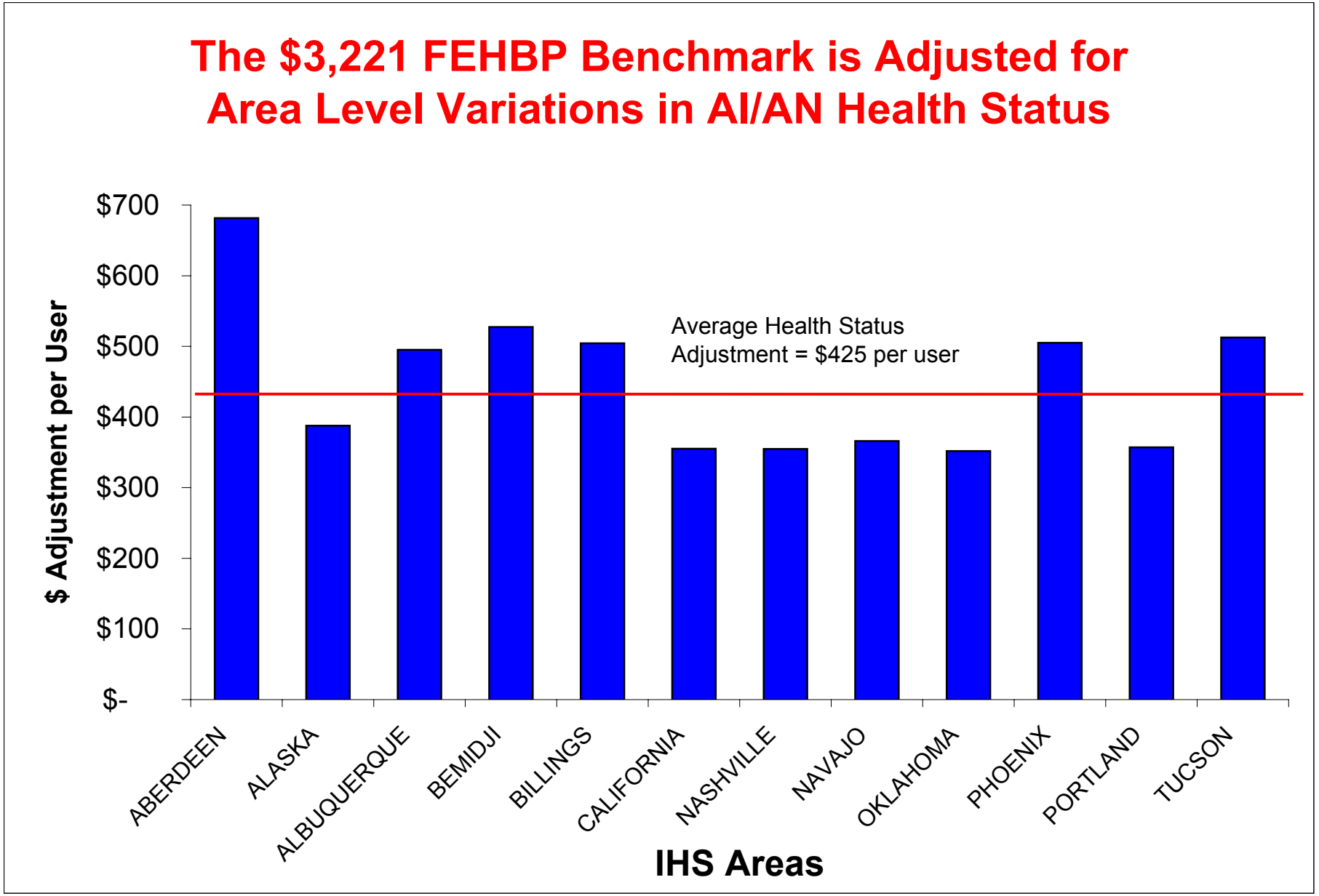


Chart 5


The $3,221 FEHBP Benchmark is Adjusted for Area Level Variations in AI/AN Health Status
$ Adjustment per User
$700
$600
$500
$400
$300
$200
$100
$-
Average Health Status Adjustment = $425 per user
ABERDEEN
ALASKA
ALBUQUERQUE
BEMIDJI
BILLINGS
CALIFORNIA
NASHVILLE
NAVAJO
OKLAHOMA
PHOENIX
PORTLAND
TUCSON
IHS Areas

The $3,221 FEHBP Benchmark as Adjusted for the Combination of Poverty and Health Status

OUs in each IHS Area cluster together because health status rates are available only as an area-wide average. Variations within each cluster are due to poverty variations among counties served by OUs. OUs above the benchmark have lower health status and higher poverty than OUs below the benchmark.

Chart 7

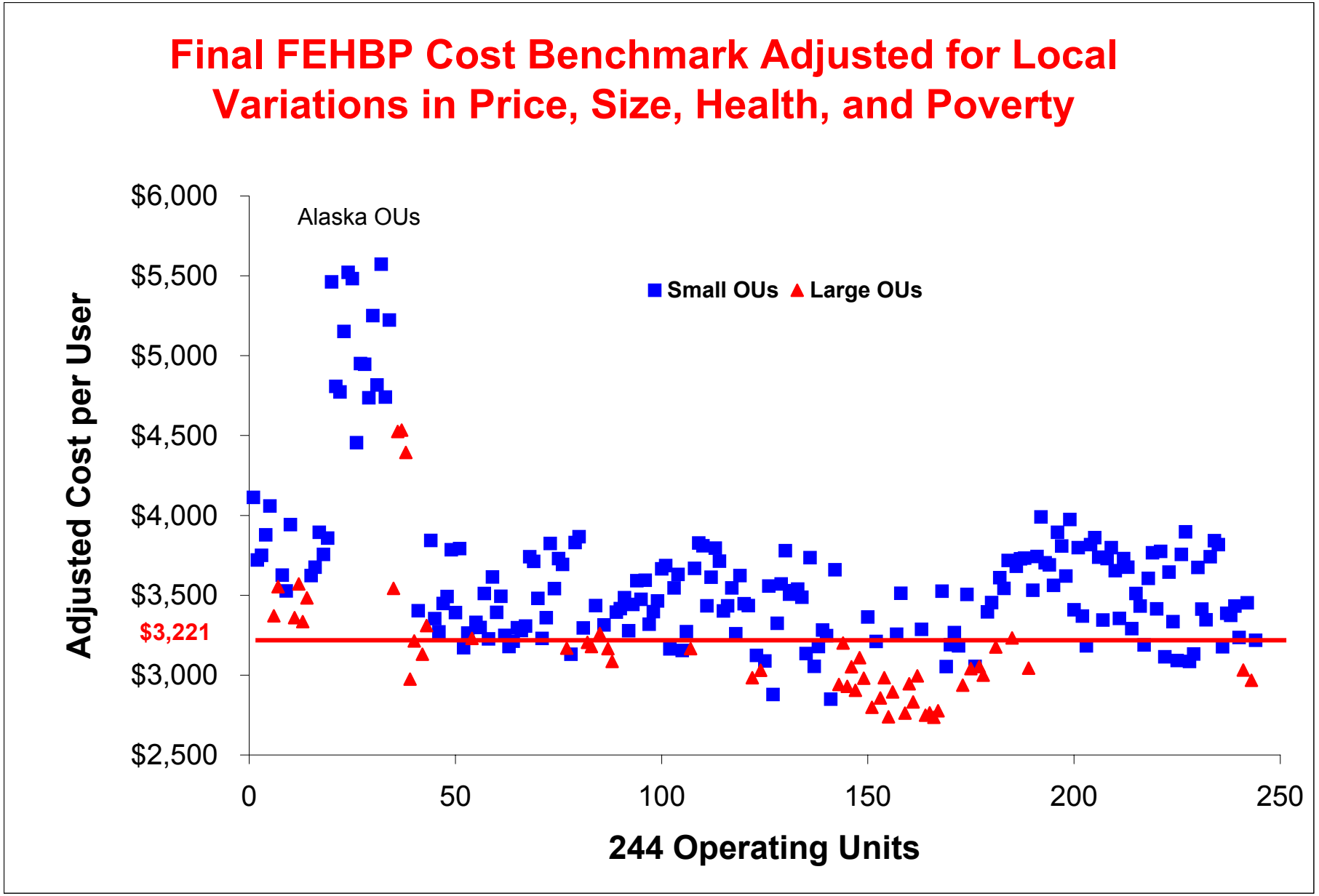
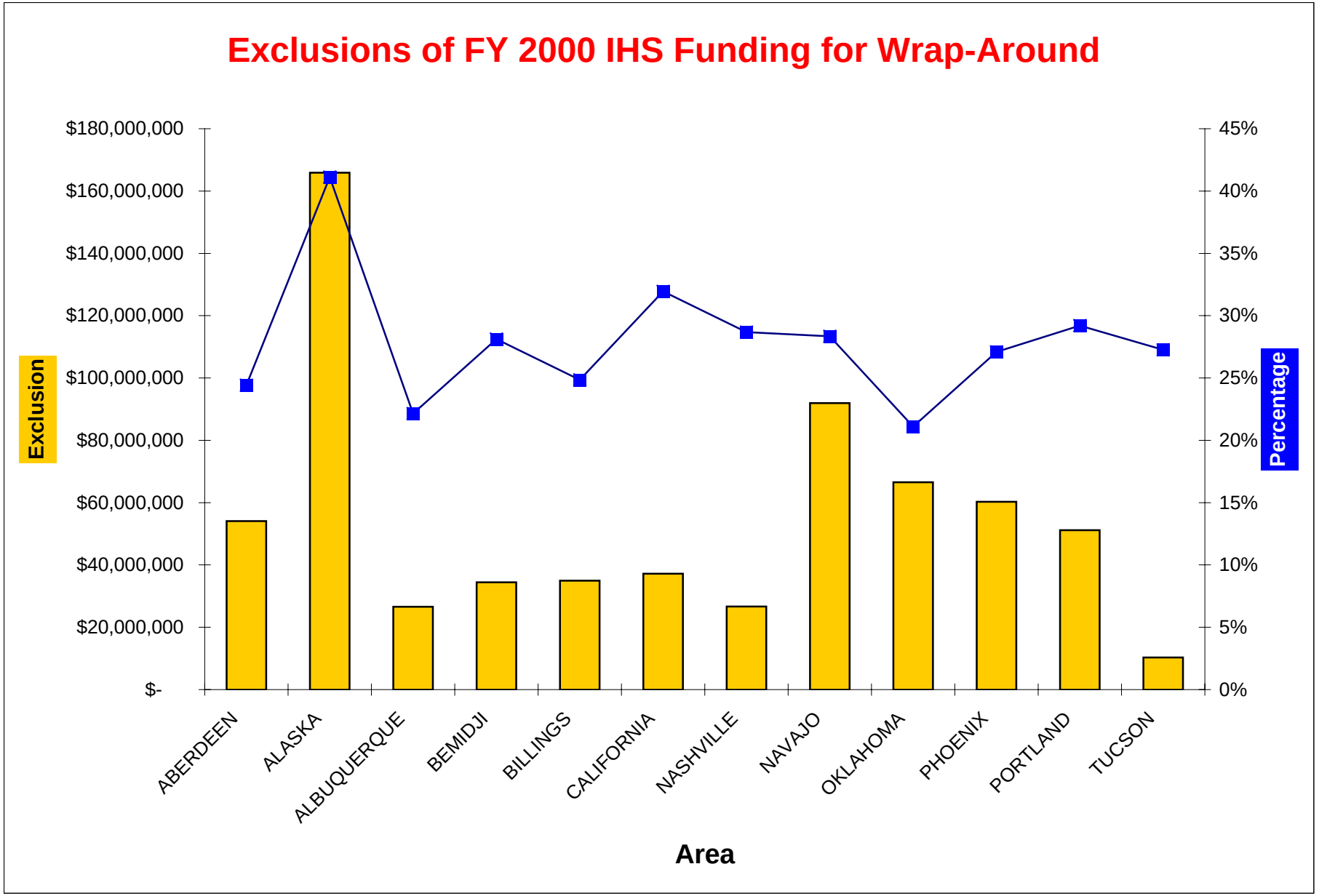

Final FEHBP Cost Benchmark Adjusted for Local Variations in Price, Size, Health, and Poverty
Alaska OUs
Small OUs
Large OUs
Adjusted Cost per User
$6,000
$5,500
$5,000
$4,500
$4,000
$3,500
$3,221
$3,000
$2,500
0
50
100
150
200
250
244 Operating Units

Chart 8


Exclusions of FY 2000 IHS Funding for Wrap-Around
$180,000,000
$160,000,000
$140,000,000
$120,000,000
$100,000,000
$80,000,000
$60,000,000
$40,000,000
$20,000,000
$-
Exclusion
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
Percentage
ABERDEEN
ALASKA
ALBUQUERQUE
BEMIDJI
BILLINGS
CALIFORNIA
NASHVILLE
NAVAJO
OKLAHOMA
PHOENIX
PORTLAND
TUCSON
Area

Is there equivalence or disparity between AI/AN medical care programs and the FEHBP benchmark?

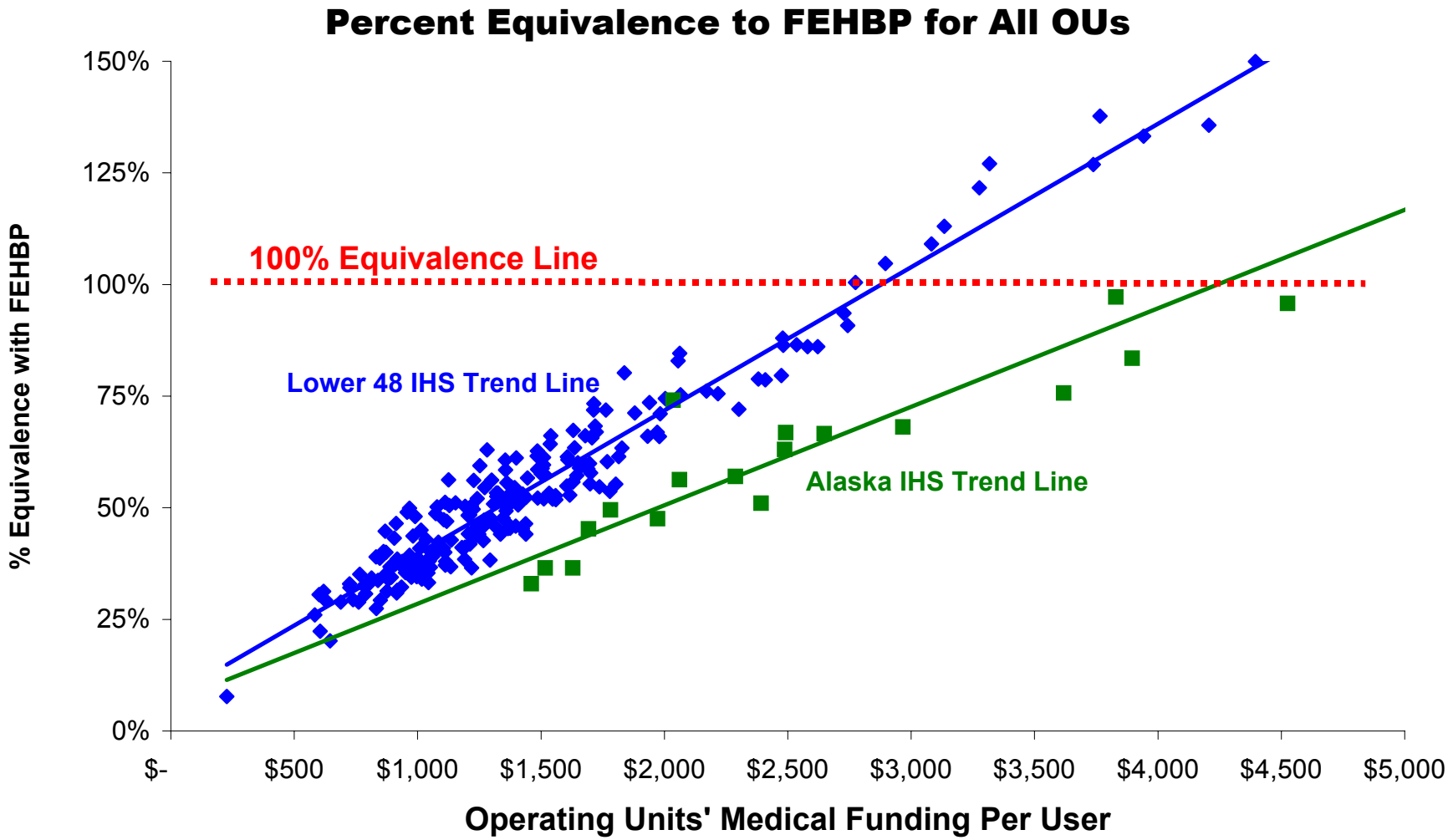
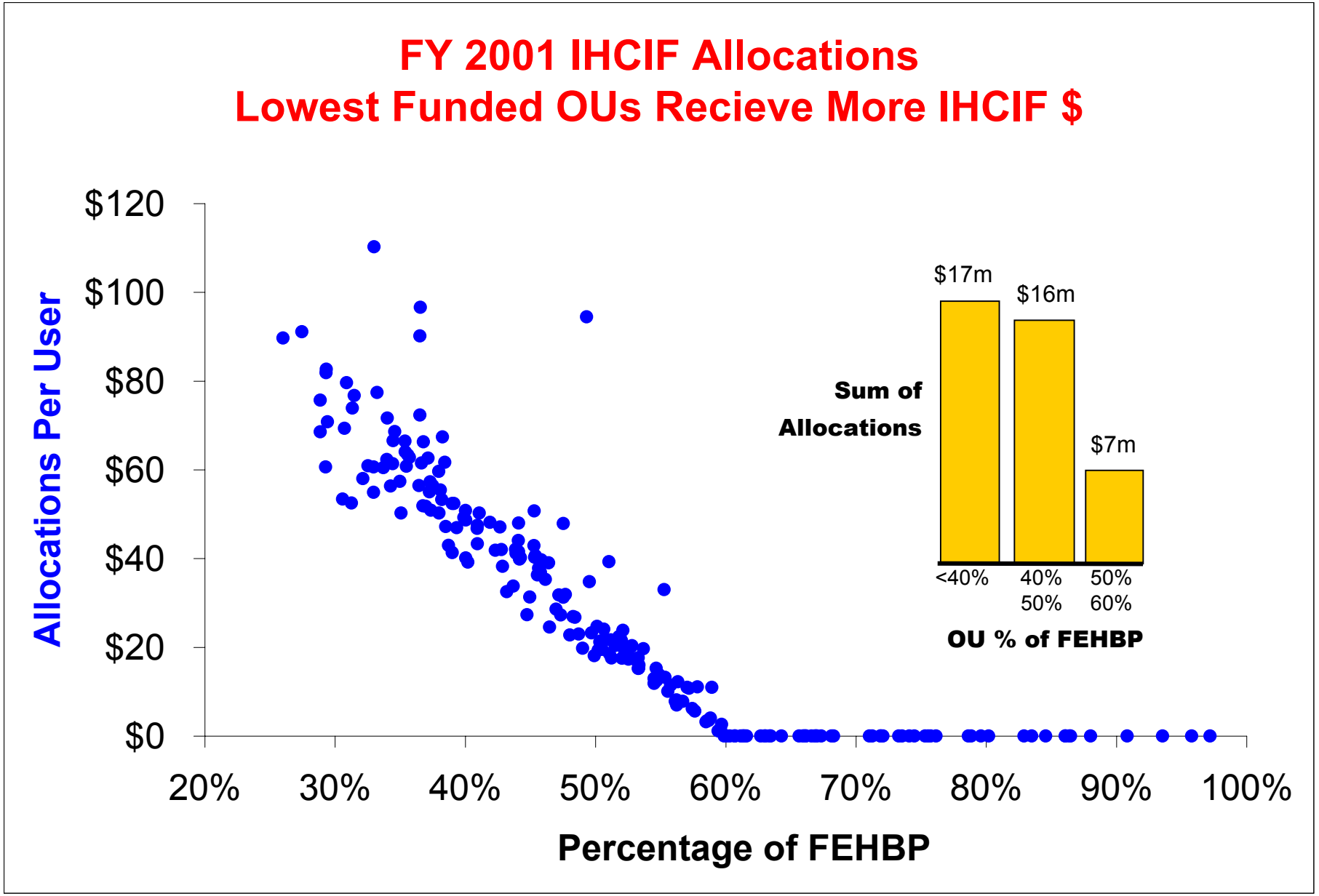


Chart 10


FY 2001 IHCIF Allocations
Lowest Funded OUs Recieve More IHCIF $
Allocations Per User
$120
$100
$80
$60
$40
$20
$0
20%
30%
40%
50%
60%
70%
80%
90%
100%
Percentage of FEHBP
Sum of Allocations
$17m
$16m
$7m
<40%
40% 50%
50% 60%
OU % of FEHBP